

*Improving Care:  
Options for Redesign of  
Washington's Mental Health System*

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## EXECUTIVE SUMMARY

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An early adopter of Medicaid managed mental health care, Washington employs a model built on the Regional Support Networks that were established in the late 1980's for the administration of state funding. The goals of the managed care program were to provide integrated and coordinated care through an organized regional delivery system that was based in local communities. The present study has found that, despite the efforts and excellent work of many, the system has not fully achieved these goals. The state, facing significantly increased budget pressures, has increasingly targeted the mental health system for reform and savings. This study, undertaken by the Mental Health Division of the Department of Social and Health Services, evaluates the options available to the state as it seeks to redesign the mental health system for the purpose of increasing efficiencies and improving the quality of care delivered.

Through the review of reports and extensive interviews with key stakeholders, a picture emerged of a system that has high levels of regional variation, limited access to care, a lack of standardized care management and unclear roles and authority between state agencies, the RSNs and some of the provider systems. Like other states, WA also needs to improve the management of state hospital utilization, increase the use of data for local planning, accelerate its gains in promoting recovery, integrate health and mental health services and use quality improvement strategies to improve performance. Numerous reports and studies have identified these kinds of issues over recent years.

New Mexico, Tennessee, and Pennsylvania provide examples of approaches that are relevant to Washington as it develops strategies to address its problems. Of the three, Pennsylvania offers perhaps the most relevant ideas for consideration by Washington. Using a carefully developed strategy developed almost a decade ago, PA has rolled out managed care to all of its counties over more than six years. The state gave Counties the "right of first opportunity" to enter into a contract if they could meet qualification requirements. Washington should consider this stepwise approach in any effort to restructure its system.

Options for improving the system, shown in the table below, include:

- improvements to the existing system,
- reducing the number of RSNs,
- managed competition,
- implementing regions with a statewide Administrative Services Organization,
- statewide managed behavioral health,
- special population carve-outs,
- carve-ins (integrated health and behavioral health services),
- chronic disease management and
- return to fee for service.

Each of these approaches offers advantages and disadvantages. Some, such as a statewide managed care initiative (carve-in or carve-out), reflect a significant change in policy direction that would require considerable political will, time and resources. Any of the options will require certain management improvements. These include changing the access to care standards, expanding the provider networks, improving the consistency and standardization of utilization management, improved procurement management and oversight, and using a more collaborative model of quality improvement. Developing a collaborative strategy to address these areas may be the best place to begin.

Virtually all informants acknowledged the need for change. While the current RSN structure offers clear advantages, it also poses many problems. While having the Counties actively involved is valuable, having larger regional entities may be a significant improvement. Managing 13 different prepaid health plans is a tall order for any agency, especially one with the limited resources available to the state Mental Health Division. Using competitive forces can help to improve health plan effectiveness, but competition must be carefully thought out and planned. Any change will require certain management improvements, new staff skills and improved procedures.

The seeds for many of the needed improvements have been described in various reports prepared under the auspices of the Mental Health Division and the Transformation Working Group, in the EQRO report and in studies by the various Institutes at the University of Washington over the last several years. The time for implementing change has come, whether it is to be through redesign or management improvement. Success will require clear guidance, delegated authority, a commitment to change by all parties and effective project management. In collaboration with its sister Divisions and Agencies, and with the benefits of the work of the Transformation Working Group, the Mental Health Division can translate its vision of recovery and resiliency and the recommendations of many stakeholders into concrete actions to improve care.

## STATE OF WASHINGTON – DSHS/HRSA/MHD

### IMPROVING CARE: OPTIONS FOR REDESIGN – ADVANTAGES AND DISADVANTAGES

Option	Advantages	Disadvantages
<b>1. Existing Structure -Improved Management</b> <ul style="list-style-type: none"> <li>Management improvements should include: <ul style="list-style-type: none"> <li>Change the Access to Care Standards;</li> <li>Increased standardization of utilization management;</li> <li>Improve contracting, monitoring and oversight through shared data, clear standards, reporting and follow-up</li> <li>Enforce contract provisions and penalties when needed</li> <li>Clarify roles and authority of MHD</li> <li>Find ways to hold MHD and RSNs responsible for outcomes</li> <li>Use collaborative QI approaches to reduce variation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Use of existing organizational model reduces disruption</li> <li>Supports a number of existing improvement activities</li> <li>May be perceived by some as maintaining a closer county connection</li> <li>Builds on strengths of current local organizations and their affiliations</li> <li>Can make changes more quickly since basic system is in place</li> <li>Saves local jobs in the smaller RSNs</li> <li>Focuses the intervention at the level closest to the community and to the families</li> </ul>	<ul style="list-style-type: none"> <li>Despite the efforts, this may result in more of the same unimpressive results</li> <li>Requires strong leadership to implement changes</li> <li>May be seen as more of what hasn't worked by some stakeholders</li> <li>County politics can continue to negatively impact the ability to reduce variation</li> <li>Difficulty in reducing level of and variability of overhead costs</li> <li>Considerable room for local variation remains (could be an advantage too)</li> <li>Improving the effectiveness of the current structure will require collaboration, trust and oversight – a new way of working together -- and will take time</li> </ul>
<b>2. Reduced Number of RSNs</b> <ul style="list-style-type: none"> <li>Requires: <ul style="list-style-type: none"> <li>The same management improvements as above</li> <li>A county governance role in the RSN, either formally or in an advisory role.</li> <li>State to administer a structured contracting or procurement process.</li> </ul> </li> <li>Consider 6 regions aligned with existing DSHS regions</li> </ul>	<ul style="list-style-type: none"> <li>Larger RSNs will likely reduce administrative costs</li> <li>Provides an opportunity for systems change while keeping the same basic business model</li> <li>Can be combined with #3 and/or #4</li> <li>Can improve or simplify coordination with the 6 DSHS regions</li> <li>Could set a lower limit on current overhead costs</li> <li>Offers continued responsiveness at the regional level</li> <li>Increases competition among providers to improve services; many RSNs will have more than one CMHA</li> <li>New rate setting efforts may be able to rebalance care</li> </ul>	<ul style="list-style-type: none"> <li>If management is not improved, the new structure may not improve care</li> <li>Requires a number of the RSNs to negotiate new governance agreements</li> <li>May require a costly new procurement or contracting process</li> <li>Absent management changes, considerable variation between RSNs can continue</li> <li>The changes will require considerable time and effort by MHD and RSN leadership, potentially distracting them from other improvements</li> <li>Could lead to some local RSN job loss</li> <li>May change roles of a number of providers who are currently subcapitated in their RSNs</li> </ul>

Option	Advantages	Disadvantages
<b>3. Managed Competition - Allow Managed Behavioral Health Organizations to Bid on the RSN Contracts</b> <ul style="list-style-type: none"> <li>Requires a formal procurement for managed competition</li> <li>Probably requires the reduced number of RSNs if private MBHOs are going to bid.</li> <li>Consider using a strategy of County First Right of Opportunity</li> </ul>	<ul style="list-style-type: none"> <li>Competition may increase cost effectiveness</li> <li>Experience in Pierce County with first private RSN may help to inform this option</li> <li>Can bring in outside expertise and leadership and/or allow for changes within current regional leadership</li> <li>National experience and outside resources are possible</li> </ul>	<ul style="list-style-type: none"> <li>May increase the costs of proposal submission by public RSNs</li> <li>For RSNs to compete against the national firms in the procurement process will be very costly</li> <li>Procurement must follow careful procedures to avoid litigation and the appearance of conflict of interest or unfairness</li> <li>Provider stakeholders and county staff may be resistant to outside leadership and organizations</li> <li>Learning curve for MBHO staff to learn about WA state</li> <li>Potential loss of local control; may reduce incentive for county revenue</li> <li>Profit margins may require lower direct service ratios ("medical loss"), perhaps offset by higher efficiencies</li> </ul>
<b>4. Regional Structure with Statewide Administrative Service Organization (ASO)</b> <ul style="list-style-type: none"> <li>ASO can be implemented with existing or reduced number of regions</li> <li>Uses a shared service model to consolidate and standardize various functions including: <ul style="list-style-type: none"> <li>information system, claims and data collection</li> <li>utilization management including state hospital - intakes and discharges</li> <li>quality oversight</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Reduces variation in administrative practices</li> <li>Can standardize data systems and claiming across the state</li> <li>Could reduce overhead costs</li> <li>Has appeal because it maintains some level of local control for case management and care coordination but has statewide standards for data and contracting</li> </ul>	<ul style="list-style-type: none"> <li>Higher administrative costs unless there are reductions in RSN and MHD administration to finance the ASO</li> <li>Significant likelihood of duplication of effort in administrative layers</li> <li>Potential duplication with Provider One</li> <li>Provider and county staff may be resistant to outside leadership and organizations</li> <li>Learning curve for ASO staff to learn about WA state</li> <li>Potential role confusion among State, ASO and RSN</li> <li>No examples of this approach being tried elsewhere</li> </ul>

Option	Advantages	Disadvantages
<b>5. Statewide Managed Behavioral Health Organization</b> <ul style="list-style-type: none"> <li>• Similar to MA, IA, MD</li> <li>• Could be risk or non-risk basis</li> <li>• Should have choice of plans</li> </ul>	<ul style="list-style-type: none"> <li>• Reduces variation in administrative practices</li> <li>• Can standardize data systems and claiming across the state</li> <li>• May bring additional experience to bear from national company</li> <li>• May increase efficiency, though the efficiency is often from reduced local services</li> </ul>	<ul style="list-style-type: none"> <li>• Overlaps with Provider One development</li> <li>• Will likely make it harder to get local/county engagement</li> <li>• Procurement will be time consuming and politically charged</li> <li>• Despite successes in some states (MA-MBHP, IA), there is no guarantee that the statewide approach will achieve objectives – NM, TN, MT</li> <li>• Further reduces local jobs</li> <li>• Profit margins of MBHOs may result in lower direct service ratios (“medical loss”) though this may be offset with higher efficiencies. Evidence is mixed nationally.</li> </ul>
<b>6. Special Population Carve-Out</b> <ul style="list-style-type: none"> <li>• Could focus on Child Welfare population and include health care services in an integrated model</li> <li>• Similar to Florida Child Welfare carve-out (Magellan)</li> <li>• May be similar to children’s behavioral health carve-out in NJ. NJ includes care management entities and an ASO.</li> <li>• This approach could include a joint governance model among MHD, JRB and CA.</li> </ul>	<ul style="list-style-type: none"> <li>• Should allow for improved access and attention to needs of kids in CW system</li> <li>• Could potentially blend Children’s Administration and JRB funds for mental health and residential services into the pool of funds, thereby increasing federal financial participation for this population.</li> <li>• Potential for greater interagency coordination at the state level</li> </ul>	<ul style="list-style-type: none"> <li>• Reduces RSN enrollment</li> <li>• Reduces RSN rates and scale</li> <li>• Requires maintenance of two systems for networks, claims, administrative processes, etc.</li> <li>• Additional administrative complexity for providers</li> <li>• Statewide or regional design?</li> <li>• Further breaks up the system</li> <li>• Not clear that any other population other than children is feasible</li> <li>• If the approach is restricted to children in state custody, this approach may require transition between health plans as children move home or into adoption</li> </ul>
<b>7. Carve-In with Health Plans</b> <ul style="list-style-type: none"> <li>• Recommend mandatory enrollment in a regional configuration perhaps with a choice of plans</li> <li>• Determine whether to include LTC</li> <li>• Consider phasing in counties and developing choice of plans</li> </ul>	<ul style="list-style-type: none"> <li>• Enables reimbursement incentives to improve health status and reduce health costs for people with mental illness</li> <li>• Consumer choice of plans may be seen as desirable to some</li> </ul>	<ul style="list-style-type: none"> <li>• No vendors with strong experience in BOTH health care and SMI/SED services</li> <li>• Inconclusive evidence from WMIP experience to date</li> <li>• Creates challenges in funding state only and block grant services since they are usually not population based</li> <li>• No current SSI enrollment in managed care</li> </ul>

Option	Advantages	Disadvantages
<b>8. Chronic Disease Management Overlay</b> <ul style="list-style-type: none"> <li>Identify/ target enrollees,</li> <li>Develop data system, telephonic and face to face intervention strategies;</li> <li>Refer to RSN and other services as appropriate;</li> <li>Consider enhanced MH benefit under FFS;</li> <li>Track outcomes and cost offsets</li> </ul> (Conceptually this strategy can cut across all RSN or FFS strategies)	<ul style="list-style-type: none"> <li>Builds on the work done by HRSA in identifying consumers with behavioral diagnoses whose physical health care costs are high</li> <li>Focusing on the 5% who spend 50% of the benefit is a high leverage strategy</li> <li>The data system and predictive modeling package has already been developed in HRSA.</li> <li>Savings are likely to be achieved first in medical costs</li> </ul>	<ul style="list-style-type: none"> <li>Presents additional rate setting challenges if the administrative costs are assumed to be in existing services.</li> <li>Depending on the underlying rate setting, CMS may raise concerns about duplication of services for care coordination</li> <li>DM models, while conceptually appealing, have mixed evaluation results in Medicare and Medicaid</li> <li>Financing system makes it hard to share medical cost savings</li> </ul>
<b>9. Return to Fee for Service</b> <ul style="list-style-type: none"> <li>Consider State as the managed care entity</li> <li>Use a waiver to allow for selective contracting and to waive statewideness</li> <li>State would implement network, UM and other functions. State may want to hire an ASO for these functions</li> </ul>	<ul style="list-style-type: none"> <li>FFS may be preferred by many</li> <li>Perceived as providing more open access</li> <li>May reduce administrative costs</li> </ul>	<ul style="list-style-type: none"> <li>Significantly increased cost risk to state for the state match requirements or for utilization – this risk will grow over time</li> <li>Reduced level of care coordination</li> <li>State currently lacks the needed skills</li> <li>Reduces or eliminates counties' incentives to raise additional tax levies for mental health services</li> </ul>



## INTRODUCTION

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Beginning in the late 1980's Washington State developed local mental health delivery systems, the Regional Support Networks (RSNs), for the administration of state funding. The State built upon this framework for Medicaid managed behavioral health care beginning in 1993. The vision for the RSNs was one of organized, effective local ambulatory delivery systems that would provide both improved quality of services and cost efficiencies. The vision was grounded in local services and in building "community"; it was driven by a system of strong local providers and county government. From 1997 to 1999, community inpatient psychiatric services and the capacity to manage them under capitation were rolled out across the RSNs. This system now has room for improvement.

In its 1998 Medicaid waiver renewal application the state articulated its vision for the system:

*Pursuant to the State's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in alcohol and drug treatment as well as services for people with developmental disabilities.... Counties are also responsible for local criminal justice systems, including local jails and juvenile detention facilities. Because of these diverse but interrelated responsibilities, RSNs maintain a unique position to facilitate coordination and integration of their existing program responsibilities with the managed mental health care system to provide seamless care for people covered by Medicaid.*

While the RSN system has realized a number of its goals, in the eyes of many it has only partially achieved the vision of "coordination ... integration ... (and) ... seamless care."

### **Goal of the Study**

The Mental Health Division of the Department of Social and Health Services retained DMA Health Strategies to conduct this study in order to evaluate the options available to the state for redesign of the mental health system. DMA's mandate was to summarize the issues facing the state and outline options for improvement and redesign of the delivery system. The goal of this paper is to inform the debate and help build consensus on the current needs. We identify the significant performance issues in the state, including regional variation and issues of access, quality and system performance, and discuss initiatives other states have undertaken to deal with similar issues. Finally, we recommend organizational and financing strategies that might lead to improvements. As with virtually every state now, Washington's budget situation is dire and cost containment is surely one goal of state administrators. While our review does not begin with the assumption that a solution must contain costs, we are assuming that options that increase costs will not be acceptable in this economy. Rather, Washington, like every other state, must strike a balance among access, quality and cost effectiveness. Ultimately all of the options must be judged by whether they can help to improve care.

### **Methods**

Information and data from numerous reports and data sources were collected and reviewed. A review of system strategies in other states was also conducted. Face-to-face interviews and/or phone calls were held with consumers, family members and other stakeholders as well staff from the Mental Health Division (MHD), the Mental Health Transformation Working Group, the state Health and Recovery Services Administration (HRSA), other DSHS Divisions, Regional Support Networks, the Washington Association of County Administrators, the WA Community Mental Health Providers Council and other agencies. These interviews offered a clear perspective on the needs of the system.

## STATEMENT OF THE PROBLEM

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Many of the problems Washington State faces are shared nationally. The 2003 President's New Freedom Commission declared that the mental health system in the United States was "fragmented and in disarray."<sup>1</sup> The Institute of Medicine's (IOM) Crossing the Quality Chasm report raised serious concerns about the state of quality in general health care delivery systems.

Treatment of chronic conditions accounts for a huge proportion of spending; 5% of the population accounts for almost 50% of spending.<sup>2</sup> Mental disorders are the fourth most costly type of chronic disorder<sup>3</sup>. One in five hospital admissions involve people with mental disorders.<sup>4</sup> Across the country, individuals who have serious mental illnesses (SMI) and receive care from mental health providers also have a high incidence of hypertension, obesity, dementia, diabetes, substance abuse, co-occurring depression (for people with other mental illnesses) and smoking. Access for people with SMI to services for these co-morbid conditions varies significantly by state and by condition. For children and families, the range of issues that co-occur with serious emotional disorders include attention deficit hyperactivity disorder, child abuse and trauma, family history of mental illness and substance abuse, educational underachievement, and juvenile justice system involvement. While the primary care sector treats people with acute and chronic health conditions, plus depression, anxiety, substance use, and obesity, according to one author, "many, if not most, people coming into primary care are being treated for psychosocial problems, not organically based medical disease."<sup>5</sup> Primary care physicians need training in screening and brief interventions. They need current information on psychopharmacological medications and access to specialists for consultation. They need a greater understanding of the services available from mental health specialists in their community and they need a responsive and collaborative specialty system for referrals and collaborative care.

Nationally, the quality of services in the mental health specialty sector is poor. While there are pockets of true excellence, when measured in terms of its outcomes the overall system falls short. People with serious mental illness die 25 years earlier than those without SMI.<sup>6</sup> Those with co-morbid chronic health problems get inadequate care.<sup>7</sup> Key population subgroups (elderly, some minorities) resist coming to behavioral health specialty providers.<sup>8</sup> Although primary care clinicians provide half of all behavioral health services, these

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<sup>1</sup> President's New Freedom Commission on Mental Health, Final Report, Achieving the Promise: Transforming Mental Health Care in America. <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm>, accessed 10/28/06.

<sup>2</sup> Conwell, L. J. and Cohen, J. W. Characteristics of Persons with High Medical Expenditures in the U.S. Civilian Noninstitutionalized Population, 2002. Statistical Brief #73. March 2005. Agency for Healthcare Research and Quality, Rockville, Md. [http://meps.ahrq.gov/mepsweb/data\\_files/publications/st73/stat73.pdf](http://meps.ahrq.gov/mepsweb/data_files/publications/st73/stat73.pdf)

<sup>3</sup> Olin GL, Rhoades JA. The five most costly medical conditions, 1997 and 2002: estimates for the U.S. civilian noninstitutionalized population. Statistical Brief #80. Agency for Healthcare Research and Quality, Rockville, MD. Web site: [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st80/stat80.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st80/stat80.pdf). Accessed April 7, 2006

<sup>4</sup> One in Five Hospital Admissions Are for Patients with Mental Disorders. AHRQ News and Numbers, October 30, 2008. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/news/nn/nn103008.htm>

<sup>5</sup> Dea, Robin. "The Integration of Primary Care and Behavioral Healthcare in Northern California Kaiser-Permanente: Psychiatric Quarterly. V71, 1, pp. 17-29: March, 2000.

<sup>6</sup> Parks, Joseph, et al. "Morbidity and Mortality in People with Serious Mental Illness" NASMHPD, Alexandria, VA, October, 2006.

<sup>7</sup> Druss, Benjamin G., et al. "Comparing The National Economic Burden Of Five Chronic Conditions", Health Affairs, November/December 2001; 20(6): 233-241.

<sup>8</sup> Unutzer, J., Schoenbaum, M., et al. (2006). Transforming mental health care at the interface with general medicine: Report for the President's Commission on Mental Health. Psychiatric Services, 57(1), 37-47

clinicians often fail even to diagnose co-morbid BH problems.<sup>9</sup> Chronic conditions are treated in accordance with guidelines only about 56% of the time.<sup>10</sup>

Washington State shares these conditions with the rest of the country. Moreover, Washington's complicated funding and organizational structure for mental health imposes unacceptable variability, limited access for certain populations, ongoing role conflict between state and local authorities and a minimal focus on recovery and resiliency. The interviews and data suggest a system where communication is sometimes difficult, training and support are lacking, and responsibilities are often unclear.

The RSNs have a strong local presence and their structure motivates county governments and local stakeholders to take an active role in advocacy for and oversight of the delivery system. A number of RSNs have also been quite successful at engaging local government in increasing funding and services for the broad community. For instance, as of April 2008, eight counties had implemented plans for special taxes to raise revenues for mental health services under SSB-5763. These funds are expected to total more than \$67 million in the first year.<sup>11</sup> At the same time, the Balanced Budget Act and CMS audits in 2003 significantly changed funding levels and funding rules, eliminating the uses of Medicaid savings for services that are not part of the state plan. Standards regulating access to care have also been tightened in the past several years to restrict RSN services for certain diagnostic groups and for certain levels of care. The result for many agencies and their consumers is that services are far from seamless and many are often stuck in inappropriate levels of care.

## CRITICAL ISSUES

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Based upon the information from informants, documents reviewed and discussions with administrators, the critical issues Washington faces include:

- Regional variation
- Poor access to care
- Need for standardized care management
- Need for stronger oversight and monitoring of contracts
- Inadequate state hospital utilization management and discharge coordination
- Minimal use of data in local planning
- Improved health care for people with mental illnesses
- Focus on recovery and resiliency
- Need for quality improvement strategies
- Unclear authority

Each is discussed further below.

### 1. Regional Variation

In its 2009 State Report Card, the National Alliance for the Mentally Ill gave Washington a C, noting moderate improvements since last year, but high levels of regional variation. As the NAMI Report Card states:

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<sup>9</sup> Ibid

<sup>10</sup> McGlynn EA et al. "The quality of health care delivered to adults in the United States". *New England Journal of Medicine*. 2003 Jun 26;348(26): 2635-45.

<sup>11</sup> Strode, Anne D. Final Report Implementing E2SSB-5763 In Washington State Counties. Washington Institute for Mental Health Research and Training, Washington State University Spokane 509-358-7614: March 2008.

*“Washington’s reliance on autonomous regional service networks creates broad variations in availability and quality.”*

Across the country, the behavioral and general healthcare fields have done little to systematically address variation in utilization and expenditures. Even where financing arrangements are identical – such as in Medicare – regional variation occurs in access to and use of health services. A regional approach such as Washington’s obviously assumes that it is appropriate to develop unique systems to meet local needs. But what level of variation is too much? When should the state and RSNs take action to reduce variation? These questions bedevil our health systems and are particularly challenging in our public mental health systems. Nationally, states and counties have generally managed through appropriations and expenditure controls rather than by using client data. Existing approaches to measuring clinical and functional outcomes have not inspired confidence. We therefore lack the appropriate metrics by which to determine what level of variation is acceptable.

Medicaid health plans are frequently held to performance standards for their medical loss ratios, penetration rates and profits as a percent of revenue. Similar accounting and claims measures have been established as part of the RSN contracts. Other types of health care performance measures include screening and immunization rates, percentage of patients who received certain procedures (eye exams, for example) medication management, etc. In mental health services, we have not been able to reach a similar consensus on industry-wide measures.

Washington State has expended considerable effort to develop data systems, reporting strategies and web based analysis tools (Looking Glass) to identify areas of variation and compare RSN performance on key performance measures. In many ways, WA is one state that has led the country in performance measurement and reporting.<sup>12</sup>

Examples of the extent of variation in mental health utilization and expenditures are:

- 2008 Community outpatient penetration rates range from 5.5% (N. Central) to 14% (Southwest) with an average of 8.5%<sup>13</sup>. The 2007 data reported in the 2008 EQRO report showed even wider variation suggesting confusion over data definitions.
- Per capita Medicaid expenditures ranged from \$271 per member per year to \$483. There was no clear relationship of these costs with RSN population.
- Total administrative costs<sup>14</sup> averaged 10.7% and yet they ranged from 6.3% to 19%.
- Direct support and Administrative costs varied from 13% in King and Spokane to 30% in Chelan Douglas. Grey’s Harbor, a very small RSN, was 14% suggesting little relationship to size of the RSN.<sup>15</sup>
- Reserve levels for risk, capitation and operations varied significantly. Greater Columbia, North Central and North Sound were very low in all areas, suggesting potential for instability in the future. Other RSNs showed very wide differences across the different reserve categories. The extent of variation suggests that the accounting standards and criteria for these reserves are unclear.
- Finally, community inpatient expenditures varied from 5% in Peninsula to 19% in King County.

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<sup>12</sup> Coleman, Mardia, et al. “Promising Practices in Behavioral Health Quality Improvement: Summary of Key Findings and Lessons Learned” Center for Health Policy Research, University of Massachusetts, March 2007.

<sup>13</sup> Data from “Looking Glass” DSHS MH Division’s Performance Indicators web site ([www.mhd-pi.com](http://www.mhd-pi.com)) - 3/11/09

<sup>14</sup> Administrative costs were collected from Revenue and Expenditure reports and include RSN, State and local administration as well as provider administrative costs. Pierce County data were excluded because of data integrity problems,

<sup>15</sup> Note that Direct Service Support and Administrative costs differ from the Administrative costs in Revenue and Expenditure reports. They include costs for utilization management, information services, public education, crisis telephone transportation, etc.

Some of the variation among RSNs is the result of inconsistent data definitions. In other areas, past efforts to try to reduce that variation were not successful. Different geographic and demographic characteristics of RSNs explain some of the variation, though most national prevalence studies do not suggest wide geographic variation in the incidence of serious mental illness or emotional disturbance. Differences in network capacity and RSN resources/rates are another possible reason for the extent of variation. Some RSNs were put on corrective action plans but there is little sense among stakeholders that this is having the desired effect.

## 2. Limits on Access to Care

When asked to identify major problems facing the mental health system in WA State virtually every person interviewed cited RSN access issues, particularly for people with moderate mental disorders and those awaiting discharge from the state hospitals. As the Mental Health Benefit Design report concluded,

*If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers.<sup>16</sup>*

After completing their study, the authors of the Benefit Design report recommended raising the GAF/CGAS score cutoff for the Access to Care Standards; under this proposal anyone with a score below 70 would receive RSN care for all diagnoses. They also recommended developing statewide standards for continuing care and discharge.

Individuals eligible for Medicaid in WA can access medications through primary care or through psychiatrists,<sup>17</sup> when they are available; but they must show certain levels of functional impairment to be eligible for RSN services. These restrictive access to care standards may mean that consumers who have moderate needs for services and who would meet CMS medical necessity criteria are still unable to gain access to the specialty services in RSNs. As a result of these standards, the intake process is lengthy and likely leads clients to drop out of care. Many respondents reported that because psychiatrists were often unwilling to contract with Medicaid the provider supply for fee-for-service was low, causing inadequate access to care. The lack of sufficient treatment can lead to increased acuity of symptoms, increased use of emergency rooms and other community crisis responses, and involvement with the correctional system.

Most other states have open access to outpatient services for Medicaid recipients: rather than gatekeeping service access, most managed care companies have moved to controlling expenditures through utilization management and moving individuals more rapidly through services rather than experiencing restrictions at the front door.

For people needing services who have other mental disorders (such as developmental disabilities, dementia and other conditions) or are served by other state agencies, to access mental health treatment for behavioral issues it may be easier to gain access to the state hospital than it is to go the RSN. The agency representatives we spoke with felt it was overly difficult for the people they serve to get access to RSN services. For many, therefore, the only access to mental health services was through the state hospital and the Involuntary Treatment Act or they had to purchase it separately, often without the Medicaid match. The results for these populations are that they can remain far too long in the state hospital awaiting community services and state staff are frequently frustrated in their efforts to seek treatment. RSNs argue that these individuals are not

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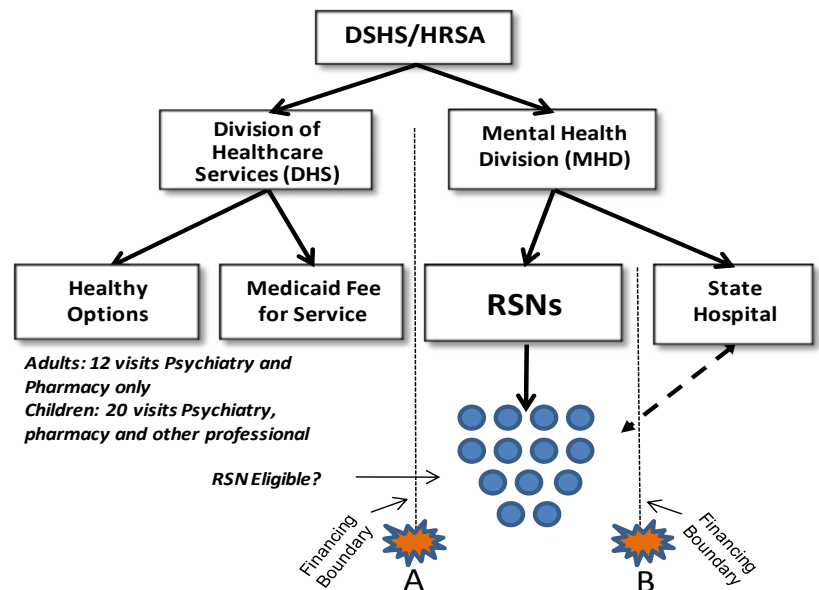
<sup>16</sup> "Statewide Transformation Initiative: Mental Health Benefit Package Design Final Report". TriWest Group, July 2007.

<sup>17</sup> For children, available services under FFS or Healthy Options also include ancillary providers such as social work and psychology.

their responsibility while other state agencies such as the Division of Developmental Disabilities (DDD) and Aging and Long Term Care Services feel that the access they previously had under fee for service has disappeared.

Figure 1 illustrates the structure of WA State's different mental health benefits and identifies the financing boundaries and flash points (A and B) for the system. There is frequent conflict over the eligibility assessments that determine RSN eligibility (A) among schools, the Children's Administration and uninsured and Medicaid eligible adults with moderate needs who are receiving services from FFS or Healthy Options. As a result, both DDD and the Children's Administration maintain their own pools of funds for behavioral treatment services. The Children's Administration maintains a separate network of mental health providers to serve their children. Unfortunately, they lose the federal Medicaid match for these services. DDD purchases some of its services from Community Mental Health Agencies giving them access to providers and improving access to RSN covered services.

**Figure 1: Existing Structure**  
**Washington Mental Health Delivery System**



### 3. Need for Standardized Care Management Processes

In order to ensure some level of consistent access to services and to meet Medicaid requirements in a regional or local structure, states must create basic standards and protocols that are implemented across health plans or regions in a uniform and seamless way. Washington's Access to Care Standards are an example of this approach to managing the "front-door" of the system. Supported by legislative authority, the state has implemented a consistent set of procedures and standards to determine eligibility for services. While there are access problems for Medicaid eligibles with moderate mental health needs, these standards constitute consistent statewide procedures. However, the EQRO report also noted that "Many RSNs have not yet implemented level of care guidelines for outpatient services. The majority of service authorizations are based solely on qualifying diagnoses....Services are authorized for six months or a year ..."18

The most recent External Quality Review Organization (EQRO) report made the following two recommendations:

- MHD needs to work with RSNs to establish standards and priorities for coordinating mental health and primary care services.
- HD needs to increase efforts to clarify the criteria for initial and continuing care, to assist RSNs in effectively managing outpatient mental health services in line with the Recovery Model.

<sup>18</sup> Accumentra Health. 2008 External Quality Review Annual Report: Washington State Healthy Options, State Children's Health Insurance Program, Mental Health Division Program, Washington Medicaid Integration Partnership, Medicare/Medicaid Integration Project, December, 2008.

They also found RSNs where comprehensive assessments were more than ten years old; clearly, there is a need for more timely assessments.

Consumers, family members, and advocates have all identified the need for a greater focus on recovery, substitution of peer support for “case management”, and the increased use of self-help tools as cost-effective alternatives to our existing delivery system. Others noted that the only way to “graduate” is to drop out; support of recovery through medication management, peer support and self-help needs to be the vision for the mental health system.

#### 4. Contract Oversight and Monitoring

The Mental Health Division has the responsibility for licensing more than 150 providers and monitoring 13 prepaid inpatient health plan (RSN) contracts. While there have been important improvements in recent years, many interviewees were dissatisfied with the quality and consistency of the state’s oversight of RSN contracts. Specific issues included vague language in the contract, lack of specificity in standards, poor measurement and inconsistency in enforcing contract terms. As one small example, we found unclear definitions of administrative costs between the contracts and Revenue and Expense reports. This appeared to lead to confusion in monitoring and accounting for those costs. Many perceived that the state lacked sufficient legislative power and authority to set standards and enforce the contract; others viewed it as a lack of political will within the Mental Health Division to enforce the standards that do exist. Still others pointed to legislative and political interference at key points in the history of the RSNs that has weakened the position of MHD with respect to them.

The EQRO report and our interviewees noted that some of the RSNs were similarly lacking in their contract oversight and monitoring. RSNs contract with providers for services but in many cases, especially in the smaller RSNs they delegate their Medicaid responsibilities for grievances and appeal, quality improvement and other functions. It is important for both the State and the RSNs to act as prudent purchasers and to manage their procurement of services efficiently and effectively.

#### 5. State Hospital Utilization Management and Discharge Planning

One of the most significant problems cited by state staff and stakeholders was the long length of stay for most individuals served at Western State Hospital (WSH). Over half the residents at WSH were reported to have had a length of stay greater than a year. As many as one third of the population were deemed to be ready for discharge. Eastern State Hospital, with an average length of stay less than 50 days, while having a greater emphasis on acute treatment services and serving a more rural population, has a significant focus on managing the length of stay. The different geography, populations and programs may explain some of the variation but practice patterns, community expectations and culture of the two facilities are likely to account for much of the difference.

There are two factors to consider in controlling state hospital utilization: 1) controlling the “front door” through a variety of diversion activities, and 2) facilitating discharges.

The “front door” is governed primarily through three separate statutes. They are the:

- Civil Commitment Statute (RCW 71.05): A person must be found to be a danger to him or herself or others, gravely disabled, or a danger to property due to a **mental disorder**. This law was amended by the legislature in 1997, 1998, 1999, and 2001.
- Community Mental Health Services Act (RCW 71.24) governs the publicly funded mental health system for people with a mental illness
- Criminal Insanity Law (RCW 10.77) establishes requirements for competency evaluations and subsequent treatment for the purposes of restoring competency to stand trial. This law was



amended in 1998 to expand competency evaluation and restoration requirements, particularly for those persons who have committed misdemeanor offenses.

In order to change the factors driving state hospital admissions, the implications of the statutes will have to be addressed in a systematic way.

Many state staff argue that there is community resistance to facilitating the discharge of individuals from the hospital; community staff reported that they often disagreed over who was ready for discharge. The debate tends to involve public safety concerns and eligibility for RSN services.

## **6. Use of Data in Local Planning and Management**

Across the country, staff in the mental health field lack training in statistical analysis that would enable them to make effective use of data. There is little experience in the use of existing survey data used in the public health arena, such as the National Survey on Drug Use and Health or the Behavioral Risk Factor Surveillance Survey. The data and reporting infrastructure has often been poorly resourced and so naturally the data is also limited.

Many RSN staff, especially in the smaller RSNs, were felt not to have the skills or the ability to use data effectively to manage care or to plan for the needs of the local population. Many also felt some state staff lacked the relevant skills. A key example is the use and understanding of data for utilization reports and for monitoring providers, including penetration rates, utilization rates, and other performance indicators. Organized health delivery systems need to actively engage in reviewing operational data and making decisions about how resources can best be used. CMHS attempts to encourage these activities through the Block Grant process. A formal planning process in each RSN with goals and objectives that can be approved by the state would be an approach to consider.

## **7. Improving Health Care for People with Mental Illnesses**

As noted above, people with serious mental illnesses have an average life expectancy of 25 years less than the general population.<sup>19</sup> Clearly, there is an urgent need to provide more comprehensive health care services to individuals with SMI. There are a variety of ways to accomplish this including the deployment of nursing and primary care staff to community mental health organizations and the development of active partnerships with community health centers. The fundamental shift that needs to occur, regardless of structure, is that health status needs to be an element of every mental health treatment plan. Blood pressure screening, brief substance abuse and smoking interventions, and diabetes testing must become routinely available for individuals at risk of these conditions.

Similarly, mental health specialists need to be available to routinely provide collaborative care to primary care providers on issues such as differential prescribing, medication and behavior management, differential diagnosis and evidence based practices. This will enable primary care providers to maintain active clinical relationships with their patients, provide access to individuals in rural settings where specialists may not be readily available, and improve the quality of care to consumers.

The recent Institute of Medicine report on behavioral health stated:

*“Collaboration by mental, substance-use and general health care clinicians is especially difficult because of...: (1) the greater separation of mental and substance-use health care from general health care; (2)*

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<sup>19</sup> Parks, Joseph, et al. “Morbidity and Mortality in People with Serious Mental Illness” NASMHPD, Alexandria, VA, October, 2006.



*the separation of mental and substance-use health from each other; (3) society's reliance on the education, child welfare and other non-health care sectors to secure M/SU services for many children and adults; and (4) the location of services needed by individuals with more severe M/SU illnesses in public sector programs apart from private sector health care.”<sup>20</sup>*

While financial incentives and the financing strategies for health plans are important to improving the collaboration between mental health specialists and primary care, they are not sufficient. Across the country, many Medicaid agencies have naïvely believed that the elimination of behavioral health carve-outs and the inclusion of these services in managed care plans would help to address both the collaborative care and specialty needs of our population. The Washington Medicaid Integration Plan in Snohomish County was designed in many ways to test these assumptions for a broad array of individuals with chronic illnesses in Medicaid. The experiences with WMIP and the data that are available have not made a compelling case for integrated financing at this time. Voluntary enrollment, the limited number of providers available, the lack of clear treatment guidelines for certain conditions and difficulties in the inclusion of the long-term care benefit have all made this pilot more difficult than anticipated. For the health improvement goals to be achieved, incentives for collaboration are needed. In some areas this may be as simple as providing a formal structure for communications among RSNs, health plans, primary care, and mental health specialists.

## **8. Focus on Recovery and Resiliency**

Washington has made considerable progress over recent years in implementing a more consumer and family centered, recovery and resiliency driven system. Through the leadership provided by the MHD Consumer Partnership Director, recent MHD initiatives have included collaboration with consumers on a legislative report (SHB 2654) on consumer and family operated services, work with the Division of Vocational Rehabilitation to develop an employment program, implementation of PACT Teams, and peer training and credentialing. While there has been progress in the Mental Health Division in identifying staff and ensuring an active consumer and family voice in planning efforts, not all RSNs have made similar progress. Despite the progress, the recent National Alliance for the Mentally Ill (NAMI) report titled “Grading the States” gave Washington State an ‘F’ for consumer and family empowerment. Washington was below average or did not score at all on the detailed questions.

The Mental Health Division and the Transformation Working Group have moved Washington State forward in a very positive direction through the active involvement of consumers and families on planning teams in the implementation of special initiatives. However, many of the staff and consumers involved in the Transformation Working Group reported feeling largely disconnected from the planning and operational decisions of many of the RSNs and to a lesser extent, the Mental Health Division. RSN administrators were also concerned that they were not sufficiently involved in Transformation Grant efforts. In the eyes of many, the involvement of consumers and families has been only on the margins of the system. They perceive that the decisions were being made without their input.

The efforts of the MHD and the Transformation Working Group (TWG) have laid the foundation for significant improvements in the involvement of consumers in Washington State’s mental health system. The changes necessary for any system to become more recovery oriented are profound. They include, among other things, ensuring consumer voice, providing consumers roles in governance, increasing consumer education and self-help, providing peer supports and encouraging a focus on employment, education, housing and social supports. Through the voice and involvement of consumers and advocates, the Transformation grant has, in

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<sup>20</sup> Improving the Quality of Health Care for Mental and Substance-Use Conditions. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Institute of Medicine. National Academies Press, Washington, DC: 2006

many ways, provided waypoints for a system roadmap. One of the key recommendations of the TWG that will make a major difference in transforming the delivery system is to:

*“Add language to the 1915(b) Waiver recognizing properly credentialed Certified Consumer and Family Run Organizations as eligible providers of Peer Support and select (b)(3) services”.<sup>21</sup>*

The Work Group that worked on the language for SB 2654 also recommended expanding authorization for the provider networks in RSNs beyond licensed CMHAs. This would allow for RSNs to contract directly with consumer- or family-run organizations, independent professionals and other organizations. It would increase competition and expand the resources available to consumers. An expanded network with a range of community options is essential for consumer choice.

## **9. Need for Quality Improvement Strategies**

There are pockets of excellence in programs and RSNs across the state, but significant variations in quality are also evident. In recent years, there has been meaningful improvement in the state’s monitoring efforts. Optimally, however, efforts to reduce performance variation through contract enforcement and sanctions should only be needed when training, technical assistance, and collaborative problem solving have failed.

The most profound change in the field over the last two decades has been the movement to managed care – a systemic but not necessarily collaborative change. Washington was at the forefront of these efforts nationally. The state’s managed care efforts were driven by efforts to control costs but in delegating responsibility to a managed care entity states also delegate a large portion of the responsibility for quality oversight and improvement. Many of the RSNs have conducted QI projects for years, but only in the last contract cycle have the RSN contracts required that annual Performance Improvement Projects (PIPs) meet CMS criteria in both a clinical and non-clinical area. The 2008 EQRO report noted that none of the PIPs “fully met” CMS criteria while only four “substantially met” the criteria. There is clearly room for improvement.

Many consumers report poor quality and inadequate communication with providers, RSNs and the state. To address these kinds of issues MHD should consider QI or performance improvement strategies with the RSNs. We found no evidence of MHD conducting PIPs or PIP-like initiatives with the RSNs.

The coordination of 13 different Prepaid Inpatient Health Plans by the Mental Health Division requires a great deal of time and resources. Quality improvement efforts need to be incorporated into the way of doing business. This requires clear agreement on goals, training, data, and a process to review and take corrective actions when needed. Far too often, our public mental health systems seek agreement without providing guidance, train without motivating staff, provide little if any formal feedback and focus on control because of the negative effects of “outliers.” In addition, the system is resource poor. Partly because most mental health administrators have risen from clinical ranks, the field is often individualistic in its approach, not system driven; the field generally manages with case studies, anecdotes and qualitative information.

In order to build quality into day to day management, the 2005 Mercer and PCG study of MHD made the following recommendation:

*Establish an administration-wide quality management (QM) program, which includes a formal plan and a QM committee with representatives of the Divisions, health plans, and PIHP/RSNs to assist the Administration with prioritizing quality improvement activities and finalizing a QM strategy.<sup>22</sup>*

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<sup>21</sup> “Report to the Legislature on Substitute House Bill (SHB) 2654: Strategies for Developing Consumer and Family Run Services”. Submitted by the SHB2654 Work Group. September 2008

Data are essential to effective quality improvement efforts. Despite efforts over many years to create data and performance reporting systems, such as Looking Glass, state administrators lack confidence in the accuracy and reliability of the data. For instance, Looking Glass has not yet been made available providers, consumers or other advocates. One means to address reliability of data is to set a clear timetable for their publication, incorporating a plan for review and correction, with the RSNs. Once the data become public, everyone shares the incentive and the urgency to correct the data if needed.

Numerous staff, RSN administrators and other stakeholders also cited the need for improvements in the support of RSNs through monthly meetings, technical assistance, data support, monitoring and oversight activities. Many stated that using a quality improvement approach similar to the approaches advocated by the Institute for Healthcare Improvement and NIATx would help to transform monitoring and compliance.

## 10. Roles and Authority

Many respondents stated that the respective roles of the state and local agencies lacked clarity. This feeling seems to derive from the pressure the state felt to improve quality and reduce variation and their simultaneous sense of being powerless since spending authority lies with the RSNs.

Two key roles of the state Mental Health Division with respect to the RSNs are spelled out in RCW 71.24.035. The functions include:

*(c) Develop and adopt rules establishing state minimum standards for the delivery of mental health services pursuant to RCW [71.24.037](#)... and ...*

*(e) Establish a standard contract or contracts, consistent with state minimum standards, RCW [71.24.320](#) and [71.24.330](#), which shall be used in contracting with regional support networks.*

Based upon discussions with state staff, there was disagreement on how and whether the State could enforce rules and standards. State staff felt that the RSNs resisted previous efforts to enforce certain minimum requirements. In addition, many RSNs delegate the responsibilities for meeting state and federal standards to providers. Although the small size of many RSNs may necessitate delegation, it exacerbates role confusion. As the NAMI “Grading the States Report” noted:

*“The MHD appears to lack authority to require specific services and doesn’t track comprehensive service and outcome data across the state”<sup>23</sup>*

## STATE INNOVATIONS, BEST PRACTICES AND FINANCING

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Nationally, the need to rethink the structure of the mental health delivery system is increasingly important in no small part because of the extraordinary budget problems all states and counties are facing. As many states are under significant pressure to cut funds and potentially to restructure, there are equally compelling forces for change in the adoption of best practice, implementing more a more recovery oriented system and creating a more data centered culture.

As a result, some states are making structural changes now. Massachusetts has recently issued an RFP for community-based flexible support services; the procurement covers over \$250 million worth of residential

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<sup>22</sup> Mercer Government Human Services Consulting. “Review of Organizational Realignment”. State of Washington Health and Recovery Services Administration, October 17, 2005.

<sup>23</sup> “Grading the States, 2009. National Alliance for the Mentally Ill. March 2009.

[http://www.nami.org/Content/NavigationMenu/Grading\\_the\\_States\\_2009/Overview1/Overview.htm](http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Overview1/Overview.htm)

and community based rehabilitative services. While not initiated in response to the fiscal crisis, the Massachusetts effort will allow the state to reduce role confusion between state and provider case managers and it will transfer some of the authority and financial incentives for coordinating rehab services to providers. This does not include acute chronic services. New York State has redesigned its mental health clinic regulations to restructure rates and change incentives; an ambulatory redesign effort is underway for both the children's and adult delivery systems.

Three states, New Mexico, Tennessee and Pennsylvania are worthy of note for the way they have dealt with some of the changes Washington State is considering. These states are particularly notable for the ways that they have dealt with blended funding, governance, County roles, and health and behavioral health integration.

In addition we identified a number of best administrative practices that states have implemented and that are worthy of further study as Washington considers other approaches. These include access policies, utilization management, quality, contracting, physical health integration, other state agency collaboration, chronic disease management, and recovery.

## **1. Innovations**

### ***New Mexico***

The New Mexico Behavioral Health system is a statewide delivery system, not one based upon county appropriations or governance. It has undergone extraordinary changes over the last four years. Beginning with a vision of interagency coordination and braided funding, New Mexico officials have pooled funding across 13 different state agencies. This was accomplished with a 1915B freedom of choice waiver for the Medicaid funding and pooled funding for state appropriations and federal grants. Joint oversight of these funds was accomplished through the creation and authorization of an interagency governance body known as the "Behavioral Health Collaborative". This entity is staffed and meets monthly to authorize spending and approve contracts. In addition to the statewide collaborative, New Mexico has created 13 Local Collaboratives that are responsible for local planning and recommendations for local funding.

Four years ago, the Behavioral Health Collaborative entered into a contract with Value Options for the Statewide Entity. This entity is responsible for managing the Medicaid and non-Medicaid funding in the system. This includes a capitated contract for the Medicaid funds and an ASO (non-risks, services contract) for the non-Medicaid funding.

The program has accomplished a great deal but the vision of a fully integrated set of services with local planning and care coordination is still not a reality after four years of planning. The first two years focused on standardizing billing and data systems. After a very short start-up period, there were significant problems in the first year due to delays in claims payment. In order to increase local planning and control, the Statewide Entity is establishing contracts with Community Service Agencies, or "lead agencies", responsible for a full array of rehabilitative and clinical services. The vision of transparent and integrated data systems is also not yet a reality. As the end of the four year contract is approaching, the Statewide Entity contract was re-procured and a new vendor, Optum Health, was selected.

New Mexico's vision is bold; it seeks to standardize and improve access, reduce barriers to care, simplify financing to promote recovery. After four years of implementation, despite many improvements, most of these goals have not yet been achieved. In these large systems and in the midst of such change, significant effort and resources are needed to manage collaboration and to maintain trust. Given the large number of participants in the Statewide Collaborative and the many Local Collaboratives, the resources needed for managing the change were probably underestimated by everyone.

## ***Tennessee***

Tennessee was one of the earliest managed care initiatives in the country. Using a CMS 1115 Research and Demonstration Waiver, the behavioral Health benefits in TennCare were initially to be administered by specialty carve-out organizations under contracts with managed care entities. These specialty organizations included several of the large national firms and some new MBHOs formed in Tennessee. The TennCare benefits included all the state and Medicaid funding and state hospital funding. In fact, this was one of the few examples where state hospital funds have been included in the managed care contracts.<sup>24</sup> The result of the initial contracts was disastrous by most accounts. Plans failed and mergers occurred. In addition, during this time and in many ways propelled by the emerging Medicaid market for managed behavioral health, the large managed behavioral health organizations went through several years of merger and acquisition. Value acquired Options. Magellan acquired Greenspring. Merit acquired CMG and within months was then acquired by Magellan.

The result in Tennessee of the combined changes in health plans and merger and acquisition, was that a multitude of separate behavioral health plans ended up with two plans both administered by the same MBHO – Magellan.

Several years ago, after a number of years of operation, the state decided to redesign the statewide effort into three regions with a full risk capitation arrangement. The rates and the terms of the contract were not adequate and the result was that three regions were awarded but contracts were not signed in two of them. As a result, the state sought to reprocurse these regions and did so with an integrated health and behavioral health benefit. They accomplished this with the two regions and recently completed the third region. As a result, a group of four health plans operate three plans in each of the three (East, Middle, and West) Tennessee regions. Each of these plans has a behavioral health contractor or a division that is responsible for the behavioral health benefits. The services are generally stable at this point in time, though no data are available on the success of the state in achieving its integration goals.

What are the lessons from Tennessee? Time is needed for planning. They learned this early on and then had to learn it again when the regional carve-out approach several years ago did not result in the three risk based contracts they wanted. Many structures can work. Success is not due to the structure but more about how people work within and across the structures to meet goals.

## ***Pennsylvania***

Pennsylvania is a county-based behavioral health system that has implemented managed care over the last eight years in successive stages across the state. Beginning with Philadelphia and Pittsburgh, then the metropolitan areas, Pennsylvania has slowly and methodically rolled out managed care across the state's 67 counties. The last contract covered the final 23 counties and was entered into by the state almost two years ago.

In what has been a very effective approach with almost no major controversy, counties were given the first right of opportunity to bid on contracts for the oversight of the capitated Medicaid system of services. If they didn't exercise the right, the state would put the contract out to bid. Until the final contract for the rural counties, all the counties, except one, exercised their right of opportunity either alone or in collaboration with several neighboring counties.

For the right to enter into these contracts, counties had to demonstrate that they had the scale and sufficient capacity and experience to manage a Prepaid Inpatient Health Plan (PIHP). To meet these requirements, all

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<sup>24</sup> Montana was the other example. In both cases, the problems for the system were not the results of including the state hospitals, though these were always a major focus of attention.

the counties entered into some variation on a contract with a managed behavioral health care organization. Other counties such as Montgomery, Delaware, and a group of Southwestern counties, contracted with one of the national BHOs. Allegheny County (Pittsburgh) was awarded to Community Care a new entity created by the University of Pittsburgh Medical Center. Philadelphia created their own managed behavioral health organization, establishing a separate non-profit organization, developing a strategy to ensure sufficient reserves and implementing required information technology and claims systems.

Since their inception, all county plans have been stable (no turnover of contractors) and the state has allocated significant reinvestment funds back to the counties to develop innovative services. Like Washington State, these reinvestment funds are subject to BBA provisions though due to tighter controls in the early years, the state did not experience the dramatic drop in CMS funding that Washington State experienced in 2003. Pennsylvania has also had a carefully planned approach to the closure of many state hospital beds and the reinvestment of these funds in the community. These policies coupled with County and state funds have helped counties achieve many of the needed goals of recovery and rehabilitative services. The approach taken by Pennsylvania has been very effective at giving counties a clear role and encouraging their collaboration. It has been well thought-out and carefully planned as it has spread from the large urban areas to rural areas. While this was no quick fix; it is a structure that will likely be sustained for many years.

## **2. Selected Best Practices**

The scope and quality of the planning that is underway on a myriad of issues in Washington State is impressive. Many excellent and well documented reports have been prepared over the last number of years on topics including utilization management, access to care, benefit design, and performance indicators. The Transformation Working Group has organized seven subcommittees and public forums to shape the 27 Outcomes that were subcommittee to TWG. Using these as a base, Task Groups were created. These groups created strategies and work plans for implementation.

In the eyes of many, however, the planning and special projects of the Transformation Working Group have been disconnected from operating activities of the Mental Health Division. The challenge for the future is how to increase the adoptions of these ideas and to better integrate the transformation planning with RSNs and with the Mental Health Division.

To help provide some benchmarks and examples of approaches that other states have taken, we reviewed several recent state procurements to look at approaches they used for the following areas: process, utilization, quality management, physical health integration, collaboration, chronic disease management and recovery. The contracts or procurement documents we reviewed include the Iowa Health Plan, the MA HMO RFPs and PA Health Choices. In addition, we summarized a number of other activities from states that we were aware of from our work. The issues are merely listed here because a more complete analysis was beyond our scope. They are intended to provide a glimpse of the kinds of activities that states and BHOs are undertaking across the country.

### ***Access***

None of the states we reviewed had the level of restrictive access standards used by Washington.

- Iowa requires assertive provider outreach to rural areas and active monitoring of utilization and access data in these areas to ensure access
- Iowa also requires an open panel – costs are not contained by restricting provider access
- MA requires initial outpatient authorization of a least 12 visits
- Iowa defines psychosocial necessity as services that meet a set of minimum standards for effectiveness and efficiency of treatment following the standards of good practice in mental health.

### ***Utilization***

Utilization management needs to focus on managing both eligibility and access to services as well as continued need for services. Standard rules for medical necessity and continued stay help to reduce length of stay and increase the use of a full continuum of community services.

- Neither MA nor PA require a standard set of utilization guidelines though the BHOs must have a written utilization plan consistent with guidelines outlined in the contract and approved by the Department. These are available for more detailed review by the State
- Iowa provides its contractor with DHS pharmacy data and requires that it monitor the prescribing patterns of network prescribers, overall utilization changes in medications, and members whose utilization of controlled substances warrants intervention
- MA requires a Health Risk Assessment be completed for each enrollee, and be used to identify enrollees needing behavioral health services or who would benefit from care management. Outreach can be directly by contractor or through PCP
- MA also requires contractor's to monitor prescription patterns of PCPs to identify enrollees who are getting psychotropic medications but not MH services and coordinate to get them into treatment when appropriate.

### ***Quality Management***

The work of the Institute for Healthcare Improvement and the Center for Healthcare Strategies have demonstrated the value of a more proactive and data driven quality improvement approach for health plans.

- The Iowa Health Plan requires five QI projects annually, no more than two of which are administrative.
- Iowa has actively participated in the Network for Improvement of Addiction Treatment to improve access and retention by identifying and reviewing licensing standards that present barriers to access and retention; pilot testing the elimination of continuing care review requirements; giving intake personnel more time to conduct intakes; and considering modifying the incentive formula to facilitate use of process improvement. These types of projects are example of the ways that a QI strategy can be used in mental health as well as in substance abuse services.
- PA's contract describes a required QM program with a comprehensive scope, addressing effectiveness of services, the provider network and administrative processes
- Both Iowa and PA require use of peer-to-peer assessment methods in addition to a Consumer Satisfaction survey
- IHP and MA require provider profiling. IHP specifies that high volume inpatient and outpatient providers who collectively represent 50% of aggregate inpatient admissions and outpatient visits be included. MA requires approval of the contractor's plan. Both require the profiles to be multi-dimensional and include comparative benchmarks. IHP emphasizes on-site visits (2 per year)
- Both MA and Iowa require the use of outcome tools: CANS, GAINS, and TOP. Both states require reporting using these tools.

### ***Physical Health Integration***

Regardless of the plan design, behavioral health providers must pay closer attention to collaborating with primary care providers, whether this is through the inclusion of primary care in benefit plans, effective screening or joint ventures between CMHAs and health clinics.

- To ensure access to services, Iowa includes reimbursement for up to 12 mental health visits provided by primary care providers in its fee for service system. The carve-out contract also describes requirements for additional primary care payments after 12 visits and under other circumstances

through the capitation. This has minimized conflict between primary care and the carve-out contractor.

- Iowa requires a plan to promote screening of depression and collaboration
- MA requires training of PCPs and behavioral health providers on the value of collaboration
- PA requires written agreements between behavioral and primary care providers regarding the interaction and coordination of services provided to Health Choices recipients. They are encouraged to develop uniform agreements to encourage consistency.

### ***Other State Agency Collaboration***

Mental illnesses affect individuals and youth in every public agency. The complex needs of these individuals require greater collaboration among state agencies to share resources and deliver effective care to people with mental illness regardless of where they live or are served.

- All three states require workgroups, designated liaison staff and/or established procedures to coordinate care with other state agencies. Washington's Transformation Work Group is an excellent example of this kind of approach. The scope of the work should be expanded.
- Iowa seeks specialized reporting on sub-populations of youth in the child welfare system for instance
- Iowa provides data and data system access to the health plan to identify case workers from other agencies

### ***Chronic Disease Management***

Chronic disease management strategies have demonstrated effectiveness using Wagner's Chronic Care Model. While few initiatives have focused specifically on individuals with chronic mental illness, depression has been exclusively replicated. Medicare disease management strategies have shown limited effectiveness though these have been limited in their focus on true chronic conditions.

- MA requires condition specific education materials for consumers
- MA requires an intensive Clinical Management program for individuals who are high risk – this includes home visiting and face to face provider consultation
- PA defines a priority eligibility group (more intense needs than federal SMI and SED guidelines) that will require specialized programming including longitudinal monitoring and disease management strategies.
- Wyoming has a structured disease management program that is one of the few in the country that includes schizophrenia, as well as depression in the conditions they identify. They have had great success and cost savings in these efforts.

### ***Recovery***

The examples listed below are but a few of the many emerging state examples of recovery oriented initiatives.

- The Georgia Peer Support Network trains consumers to be certified peer specialists who are eligible for Medicaid reimbursement under changes to the Medicaid State Plan. California, Massachusetts and numerous other states have replicated this in order to qualify consumers for Medicaid reimbursement. Washington has certified more than 200 peer specialists, however, a fraction of these have actually been able to get jobs since they rely on being hired by the CMHAs. In their recent procurements, New Mexico and Iowa require the contractor to establish a certified peer counseling program. Like Washington, all the states are wrestling with how to pay for these services.
- New Jersey Consumer Connections, run by the Mental Health association, trains consumers for employment in the mental health field. It includes an Employment Opportunity Bank, Consumer provider training and consumer support network. It is an example of the important shift in focus that is required if we are going to



- Florida's Self-Directed Care program allows consumers to direct funding for services from their own spending account according to their own personal recovery plan. The services have been replicated in Hillsborough County FL for children in the child welfare system. Oregon and Texas have current self-directed care initiatives and Delaware County PA is implementing a similar effort, the first to use Medicaid services as a part of the self directed mental health care fund.
- New York has implemented and MA has replicated what they refer to as the "Bridger" program. This uses certified peer counselors to provide support for individuals as they are discharged from inpatient and state hospital services. The services are time limited and focus on ensuring access to treatment and community supports, housing advocacy, and social supports.
- Person centered planning has been a cornerstone of Michigan's regulations and part of many years of training and support in the Western NY Care Coordination Project. Shared decision making is a similar approach detailed by the staff at Dartmouth and by Pat Deegan, a consumer researcher who has developed software to be used in the waiting room to assist treatment decision making when the consumer is with the physician. This approach is currently being piloted at Community Care, the BHO in the Univ. of Pittsburgh Medical Center Health Plan and at many providers across the country.

In any future procurement or contracting effort, Washington should consider incorporating elements of the above approaches as a part of the scope of services.

### 3. Financing and Contracting

#### *Financing Options*

The optimal financing options vary somewhat for each of the organizational approaches described in this report. In different types of managed care, the financing can be structured to shift financial risk from the state to the health plan of providers. This is accomplished through the use of:

- Blended rates – A rate that covers several different types of services and is paid to a provider on a per person per day for the duration of their treatment
- Case rates – A rate paid for all the services needed for a person for the episode of care. A DRG (Diagnosis Related Group) rate in Medicare is a good example. Another would be a payment to hospitals per admission, regardless of the length of stay.
- Capitation rates – payments generally to health plan for all enrollees in the plan, regardless of the number of "users" of service.
- Global budgets – A flat payment to a health plan or provider for all the services needed in a community. This reimbursement method is generally used when there is no clear count of the population to be covered.

In each of these types of rates, a different level of financial risk for services is transferred. Each requires a different way to administer the funding. They are appropriate for different programs depending on the nature of referrals, eligibility rules, scale of the programs and other factors.

WA has a well-developed capitation approach for the current RSNs, though there were complaints about the differences in capitation rates across the different RSNs. The 2003 BBA audits had a major negative impact on rates and state funds were appropriated to supplement the Medicaid funding. Consolidation of some of the smaller RSNs may help to reduce some of the geographic rate variance. Implementing an incremental approach to reduce the rate variation, while remaining within the statewide capitation limits might also be a strategy to reduce variation. Montana recently targeted certain new appropriations to reduce the funding variance among regions of the state.

### ***Performance contracting***

Increasingly states are moving in the direction of requiring performance incentives as a part of their state and health plan contracting. While the research is mixed on the results of performance incentives<sup>25</sup> the public policy direction is clear – public funding needs to be more clearly tied to outcomes. There are two fundamental issues in adopting effective performance contracting: 1) ensuring that the measures are meaningful, difficult to “game” and widely accepted and 2) providing a sufficient incentive to capture attention and to reimburse for the changes necessary to achieve them.

Several examples from other states are useful to consider:

- Delaware implemented performance-based contracting that provides financial rewards to providers who are able to engage and retain clients in substance abuse treatment. Many have argued that these “Washington Circle” measures are equally relevant to mental health.
- Kentucky’s Department for Mental Health and Mental Retardation Services (KDMHMRS) has engaged in extensive internal planning & change in processes in order to utilize performance based contracting strategies. For FY ’05/06, 5% of state funds were used for performance incentives.
- Oregon requires that 50% of state funds are devoted to Evidence-Based Practices (EBP) by 2007-2009 and 75% by 2009-2011. This law has greatly accelerated the identification of evidence-based practices and provider adoption of EBPs even as it met with great opposition from providers.
- MA and Iowa both require some implementation of provider incentives. Iowa requires this on a pilot basis and MA requires the use and implementation of some type of incentives.

The Massachusetts contract with the Massachusetts Behavioral Health Partnership (Value Options) is an excellent example of the use of performance contracting. Annually, using a significant portion of the firm’s negotiated profit margin, the state develops and negotiates a set of performance incentive projects (PIPs) that trigger incentive payments when the projects are implemented. Examples include a variety of special projects, achieving certain performance measurement goals and special projects. There has been some debate in recent years that these incentives have shifted too far from performance measures to the implementation of special projects. However, the overall impact has been very positive and the allocation of a pool of funds for annual initiatives has ensured that the program continues to meet the needs of the state, remains relevant and is innovative.

Ultimately, all mental health delivery systems need to move more aggressively to some form of value based purchasing (VBP). To begin, VBP efforts must clearly define value; this is where the behavioral health field lags behind the rest of health care. We are not content to allow our definitions of value to derive from claims related criteria such as post discharge follow up, readmission, etc. We certainly are not comfortable having payments made based upon these data.

## **STRUCTURAL OPTIONS FOR REDESIGN**

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Based upon the approaches that various states are using to structure their Medicaid managed care initiatives, the state could consider several different financing and organizational options. All the options require a number of management changes by MHD and by the regional or statewide management entities. Making these changes requires commitment and clear authority; it also requires careful planning training and the support of MHD and other staff. While we review most of the options, only several are feasible given the

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<sup>25</sup> M.B. Rosenthal et al. “Early Experience with Pay for Performance: From Concept to Practice.” *Journal of the American Medical Association* 294, no. 14 (2005): 1788-1793.

current reality. Clearly, the economy and revenue forecasts overshadow all policy changes and may force reductions in benefits and budgets. Many have argued that any reorganization should not be enacted, regardless of the savings projected, until the many recommendations that have already been made by many different stakeholder groups have been implemented. Nonetheless in the sections that follow, we review the options, highlighting their structure, implementation issues, and advantages and disadvantages. Each option is also summarized in the table at the end of the Executive Summary. We are confident that through an open discussion of these issues, care can be improved.

## 1. Improvements in the Existing Structure

The state's first option is to keep the existing organizational and financing structure while making other changes needed to improve access, quality, and efficiency and to transform the delivery system. Many will argue that the state tried to make improvements in the past and most efforts have not succeeded. These people believe that only a change in structure will accomplish the needed improvements. Others will argue that the use of the existing structure allows for more rapid changes and reduces disruption. Sometimes a reorganization or restructuring can make it easier to implement changes by reorganizing staff, changing job responsibilities, and taking the time to plan new work procedures.

Many of these options are not new. Advocates and other stakeholders have made these recommendations over the last several years. In particular, the Mental Health Transformation Project and the broad array of stakeholders who participated in their various planning meetings have proposed similar recommendations. The management changes include the following:

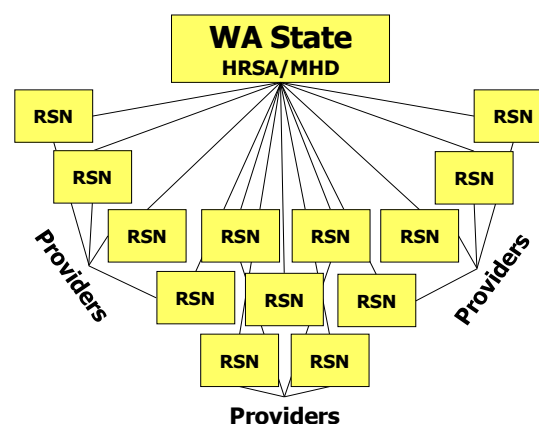


Figure 2: Existing Structure – Option 1

### ***Change the Access to Care Standards***

Several previous planning efforts have recommended this. The changes recommended in the Benefit Design report<sup>26</sup> should be the starting point for improvements. Unfortunately, changes to the access standards may require increased rates to RSNs. One way to achieve this, at least theoretically, might be by eliminating the 12-visit benefit for SSI eligible adults in fee for service and 20-visit limit for children in the Healthy Options program. The outpatient benefit could be offered instead by the RSN and their rates adjusted accordingly. The RSNs would be responsible for the full mental health benefit in the region. By providing the financing for more open access to outpatient services, the RSNs will be better able to assess and provide brief intervention for community members. The lengthy intake process could be reduced and the costs associated with it. This will help to reduce the perceived access barriers that many stakeholders reported.

If this first approach is not possible, the state should develop a work group of state and RSN leadership to standardize assessments and set guidelines for treatment planning. The assessment and treatment plans, obviously need to be consistent with new Medicaid regulations when they are adopted, but they also should reflect person/family centered and recovery oriented principals.

### ***Network Changes***

RSNs should be authorized and required to expand their networks to increase competition and the diversity of services. Current rules allow RSNs to contract only with MHD licensed community mental health agencies

<sup>26</sup> "Statewide Transformation Initiative: Mental Health Benefit Package Design Final Report". TriWest Group, July 2007.

(CMHAs). While protecting CMHAs, this restriction places a significant barrier on competition in the RSNs; and in many areas, it has limited the growth and availability of certified peer support staff and family and consumer-run services. Expanded networks should include consumer/family operated services, independent licensed practitioners, and other providers. Standards for the credentialing and approval of organizational providers should be developed and included in RSN contracts. Collaboration among providers and between RSNs can help to make these credentialing changes less costly. The increased availability of a range of providers should significantly help to improve consumer choice and quality of services. The competition is likely to also improve performance over time. If the existing RSN structure is maintained, changes to contracting rules will be particularly important to improve cost effectiveness and increase the use of peer support and other providers.

### ***Standardize Utilization Management***

Numerous interviewees identified the need to implement statewide standards for concurrent and discharge planning. The Mental Health Transformation Project commissioned a report that has made detailed recommendations to standardize the UM process in RSNs. It should apply to community hospital, state hospital and community services in a way appropriate to the intensity, cost and frequency of the service. Instead of managing costs through gate keeping at the front door (through the Access to Care Standards), RSNs should focus attention on inpatient diversion opportunities and more active outpatient assessment and treatment planning.

### ***Improve Contracting, Monitoring and Oversight***

Many improvements in RSN contracting were implemented in the most recent re-procurement effort, but according to many, the contract could be further clarified in several places so that outcomes and performance are more measurable. New MHD compliance staff have taken positive steps to improve contracting through more detailed audits and technical assistance to regional support network staff. These activities need to be sustained. It is important to develop the role of MHD as a prudent purchaser of mental health plan services. The concepts and approaches outlined in the work that Bailit Healthcare Purchasing did for the Leapfrog Group can be very useful as a purchaser's guide.<sup>27</sup>

Numerous individuals cited the failure of the state to enforce existing RSN contract provisions as a major reason for variations in quality and performance yet we did find examples of corrective actions and other enforcement efforts. Given the problems mentioned above with contract language and data, the lack of consistent enforcement of these provisions is not surprising. The new compliance staff will help, but leadership must also ensure that MHD efforts are consistent, measured and enforceable.

Increasing access to and transparency of data will help to improve trust in the system, reduce conflict and will dramatically improve the quality of data over time. MHD has made an important investment in "Looking Glass", the state's performance indicator reporting system. The data contained on this site are very useful in monitoring services. Access, utilization, quality, and expenditure data are all available on a statewide basis and for each RSN. However, access to these data is currently limited to MHD staff and only a limited number of staff in each RSN. Steps should be taken immediately to fully review the data, identify any needed footnotes or qualifiers and open the site incrementally to all RSN administrators, local officials and the general public.

Through shared data, clear standards, reporting and follow-up, the state can make many of the improvements needed. To accomplish these improvements will require dedicated staff resources. The Mercer study in 2005 provided a blue print for many of the details that should be considered in looking at staff and resource

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<sup>27</sup> Bailit Health Purchasing, LLC. *Value –Driven Health Care, A Purchaser Guide*, Version 1.0, February 2007. [http://www.leapfroggroup.org/news/leapfrog\\_news/Purchaser\\_Guide](http://www.leapfroggroup.org/news/leapfrog_news/Purchaser_Guide)

deployment.<sup>28</sup> Mercer made many of the same recommendations made in this report. This may require that resources are used differently or that shared services are developed with other divisions in HRSA. This will require support and leadership from within MHD, and a new sense of collaboration among MHD, HRSA, RSNs and providers.

### ***Implement a Routine Planning Process***

Washington State should require, as a part of its contract with the RSNs, that they implement a formal biennial planning process in a way that optimally would provide the data and the recommendations for the state plan. These plans should be simple in nature, page-limited, action oriented, data driven, and inclusive of key public and private stakeholders in the RSN area.

### ***Implement Performance Contracting and Interagency Collaboration***

RSN performance measures currently include “time to post-discharge services” and “time to first appointment”. These are steps in the right direction; more must be done. The use of non-clinical PIPs by several RSNs on the time to first appointment measure promises to both improve performance but also lead to refinements on the data tracking ability of the RSNs. Providing some type of incentive for RSNs that achieve the standard is an approach that should be considered. It can be started slowly, with limited financial impact and then increase over time. The Evidence-Based Practice Institute has also made recommendations for incentives to encourage adoption of evidence-based practices by RSNs.<sup>29</sup>

In addition, there are opportunities for the state to improve interagency collaboration by expanding the scope of various interagency initiatives. This has been a focus of the Transformation Working group in recent years and is an expansion of the excellent work that has been accomplished between MHD and DVR to develop a supported employment initiative, MHD could establish an oversight entity to coordinate interagency programming with the other key agencies including the Division of Healthcare Services, the Children’s Administration, Aging and Disability Services Administration, Division of Vocation Rehabilitation, the Juvenile Rehabilitation Administration, Department of Corrections and others. This is also consistent with one of the recommendations of the Evidence Based Practice Institute<sup>30</sup>. It will require regular meetings, clear direction and authority, a common purpose and clear priorities from among the many possibilities. Building upon small successes, these state agencies can make significant improvements in services, data and quality for individuals with mental illnesses that are served by the various agencies.

### ***Use Collaborative QI Approaches to Reduce Variation***

To accomplish the goals of reducing variation and improving quality, the Health Resources and Services Administration (HRSA) should consider additional steps to integrate the DHS and MHD quality strategies to develop a coordinated approach to managed care for physical and mental health.<sup>31</sup> The experience and perspective of HRSA staff in health plan quality improvement can be very important to the Mental Health Division’s quality strategy. The system would benefit from adopting approaches used by national organization such as NIATx, Institute for Healthcare Improvement and the Center for Health Care Strategies. These efforts are particularly effective in developing a shared “culture of quality” while staff are working on real business challenges. Participants should include RSN staff or providers depending on the topic.

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<sup>28</sup> Mercer: Government Human Services Consulting. “Review of Organizational Realignment”, October, 2005.

<sup>29</sup> Evidence Based Practice Institute, “State Mental Health Comparison Report: Innovative Practices” University of Washington: December, 2008

<sup>30</sup> Ibid

<sup>31</sup> 2008 External Quality Review Organization Annual Report: Washington State Healthy Options; State Children’s Health Insurance Program; Mental Health Division Program; Washington Medicaid Integration Partnership; Medicare/Medicaid Integration Project, Acumentra Health, December 2008.

In addition, as funding permits, the Mental Health Division should consider developing Technical Assistance Centers as recommended in the STI Mental Health Benefit Package Design Final Report. The Evidence Base Practice Institute is an example of such an approach. These Technical Assistance Centers should support the implementation of evidence based/best practices similar to New York and Hawaii Centers for Excellence. These centers can be used to provide training and technical assistance, quality improvement and outcome monitoring activities.

## 2. Reduced Number of RSNs

One way to achieve some efficiency in the administration and oversight of the system would be to reduce the number of RSNs in the system. While this reduces the number of contracts to oversee, it does not change the need to make many of the improvements described in Option 1. A focus on contract monitoring, oversight, improved access, standard utilization management practices and quality improvement is still needed. To implement the reduced number will require a procurement or structured application and contracting process. This is likely to take time and effort.

If the number of RSNs is reduced, the state should encourage and establish guidelines for Counties to take a formal governance role in establishing the new regional entities.

This would include Board involvement, formal votes on approving state contracts and on the allocations of funds, and a clear structure and incentives for the use of county revenues that might be contributed to the RSN. If County officials do not agree to participate in a formal role, another stakeholder representative should be appointed by the County or by the State. Pennsylvania has implemented this by establishing certain standards for size, skills and resources for each plan. Counties have the right of first opportunity to deliver the services based upon a detailed process of contract negotiation.

Reducing the number of RSNs has the advantage of scale; there are fewer contracts to execute and monitor and there would be an increased size and scale of several RSNs to allow them to have the needed infrastructure to develop the network, manage utilization and improve quality. This larger scale would likely reduce administrative costs and could improve the level of staffing for some of the RSNs. If the number of RSNs was reduced to six, the geographic boundaries could be configured to match the DSHS regions, making it easier for different agencies to collaborate and coordinate care and develop new programs.

The increased size of the RSNs would help to increase market competition among providers and reduce the current dependence of RSN administrators on a single provider. Of course it would also change a number of providers' roles and responsibilities in their RSN. Because of the restructuring, new RSN rates would have to be set for at least four of the regions and this can provide an opportunity for rebalancing funds across the RSNs. This could also be a time to establish clearer definitions on administrative costs in order to set limits on costs. These and other changes will take considerable time to accomplish; a minimum of a year and a half for the new RSNs.

## 3. Managed Competition

A variation on the current RSN model or Option 2, is to allow (in fact encourage) public and private competition for RSN contracts with the state. The recent RSN contract award to Optum Healthcare for the Pierce County RSN is the first to be awarded to a private entity. Many RSN staff fear that this is the first of

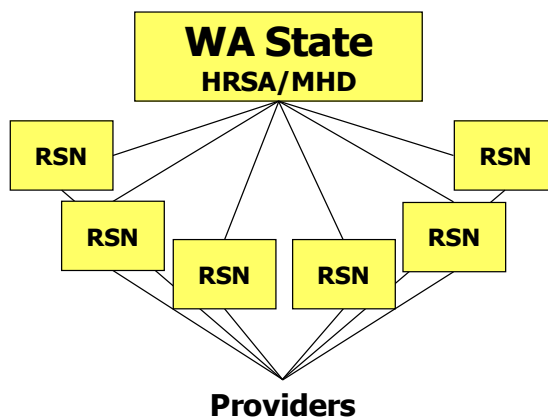


Figure 3: Reduced RSNs – Option 2



more private contracts to come, however, Optum brings a national experience, technology, and depth of resources that will be likely to benefit Pierce County.

Across the country, state and county administrators have often argued that private sector, or managed, competition with government agencies can be a force to significantly improve public performance<sup>32</sup>. A recent report by the San Diego Institute for Policy Research and the Reason Foundation<sup>33</sup> stated:

*Managed competition is different from simply “outsourcing,” or “contracting out” in that it encourages public employees to submit bids and compete with private bidders. Thus, it is a way of bringing private-sector competitive pressures and incentives to the public sector.*

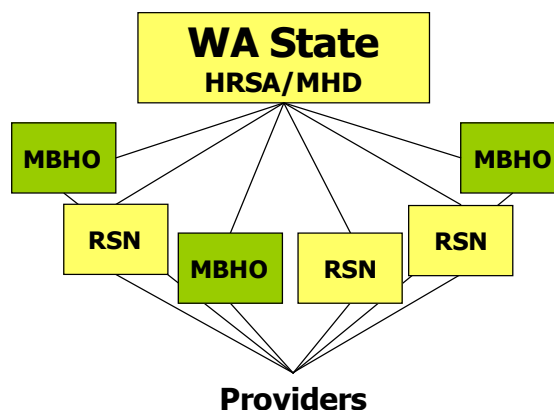


Figure 4: Managed Competition

Certain jurisdictions have been successful in this approach when the efforts were carefully planned out and there was a consistent and strong leadership from the top levels of government to support the initiative. However, most of the successes have been in the delivery of municipal services such as trash disposal, water treatment, fleet maintenance, parks and recreation, information technology and services. There have been few successful efforts in healthcare or human services. The basic principles are the same, however.

As discussed above, Pennsylvania adapted some elements of the managed competition approach in its administration of the Pennsylvania Health Choices program for behavioral health services. Similar to Pennsylvania, Washington could consider a county “first right of opportunity” or “first right of refusal” approach. Washington State will require a carefully planned and cautiously executed procurement process to implement such an approach. It probably requires that many of the smaller RSNs be consolidated into a reduced number of regional entities in order to encourage competition. The advantages to such an approach are that competition can potentially increase cost effectiveness and can bring in outside expertise and leadership. The experience in Pierce County with the first RSN may help to inform this option. With the introduction of competition in the public delivery system, providers and county officials may be more likely to recognize the significant need for change in utilization management, improved access, contracting and oversight.

Disadvantages include the increase costs of proposal preparation for public agencies in order to compete with private entities. There are also significant risks of litigation from municipal authorities, public employees and others. As a result, the procurement must follow careful procedures and avoid any appearance of conflict of interest or unfairness. As with other privatization initiatives, the award of a contract to a new private entity may lead to resistance from provider and county staff and is likely to require time for outside staff to learn about Washington State and develop the needed relationships. Finally, the profit margins of for-profit organizations may result in lower direct service ratios, though this can be offset by higher efficiencies in administration.

<sup>32</sup> David Osborne and Peter Hutchinson, (2004) *The Price of Government: Getting the Results We Need in an Age of Permanent Fiscal Crisis*. New York: Basic Books.

<sup>33</sup> Segal, Geoffrey et al. (2007) “Streamlining San Diego: Achieving Taxpayer Savings and Government Reforms through Managed Competition” San Diego Institute for Policy Research and Reason Foundation.

#### 4. Regions with Statewide Administrative Service Organization (ASO)

The fourth option involves a statewide RSN system with a statewide Administrative Service Organization (ASO) to consolidate and standardize various administrative functions. These ASO functions might include information, claims and data collection systems, utilization management and quality oversight.

A single ASO can reduce variation in administrative practices and standardize data system and claims processing across the state. The approach has some conceptual appeal but in order to be cost neutral, funding the costs of the ASO could result in reductions in both the MHD and RSN budgets. A statewide ASO could potentially reduce overall administrative costs, though there is a likelihood of some duplication of efforts across the administrative functions that would have to be performed by providers, the RSNs, the ASO and MHD. Compared to a statewide managed behavioral health organization option, this approach could maintain regional care management functions and some local governance. The implementation of DSHS' new Management Information System, Provider One, could also be a part of the solution, though this can also complicate things and make accountability for performance more difficult to determine. Given the current funding and structure of the system in WA, this approach is likely to require some additional funding for the added administrative services.

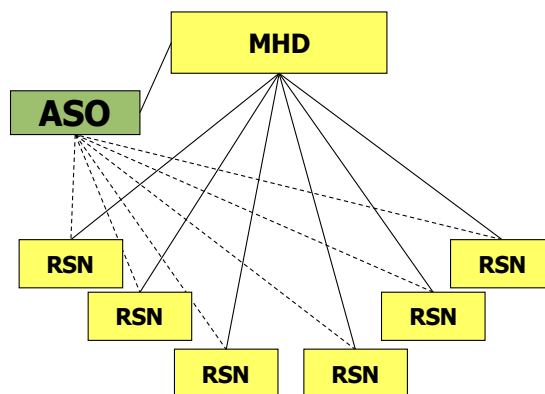


Figure 5: Regions and Statewide ASO

There are no directly comparable examples of this approach (ASO with Regional Networks) being used successfully elsewhere in the country in a county- or regionally-based system. San Diego County attempted to implement this and to develop lead provider systems for geographic areas of the county. The effort was terminated because of the perceived duplication of overhead. Meanwhile, Massachusetts has had a statewide managed care contractor for many years. In response to a lawsuit settlement, the state is developing lead Community Service Agencies (CSAs) for the state's children's mental health system. These agencies will be responsible for coordinating community-based care while the state's ASO will oversee and manage inpatient and residential care. Unlike the RSNs, the CSAs will not be at risk for the full range of services. California has an ASO contractor working with counties and providers for the management of its children's residential services.

#### 5. Statewide Managed Behavioral Healthcare Organization (MBHO)

Implementing a statewide managed behavioral healthcare organization would involve a dramatic shift in the structure and design of the state's mental health system. Similar to long standing approaches in use in Massachusetts, Iowa and Maryland, the statewide MBHO would be responsible for access and eligibility, utilization management, processing claims, reporting, and quality improvement. It would reduce variation in administrative practices and standardize certain data and reporting systems; however, it would also reduce local control and could reduce incentives for local revenue. Conceptually, it should be more efficient than the current design due to the consolidation of administrative activities. It also may bring outside expertise to assist the state with transformation.

New Mexico is the most recent national example of a statewide behavioral health contract. The "Statewide Entity" holds a contract with the New Mexico Behavioral Health Collaborative. The contract includes a capitated contract for Medicaid services and an administrative service contract for state and non-Medicaid



funding. The statewide entity holds all network contracts, pays claims, monitors quality and reports on services and expenditures to all funding sources.

DSHS's current efforts to develop Provider One, if successful, could provide some of the same advantages for data systems as the statewide MBHO approach; there could be efficiencies from combining efforts. While there may be efficiencies in administration, the addition of profit margins may also result in lower direct service ratios. A statewide approach might also reduce local jobs.

Despite successes in some states, there is no guarantee that a statewide initiative will be satisfactory. Montana's and Tennessee's statewide contracts are examples of system where the approach did not work. As with some of the other methods, a procurement would be necessary to implement a statewide approach. This would be time consuming and politically charged. New Mexico's recent decision to award its statewide contract to a new contractor has resulted in an appeal. There were no changes in the financing structure during the procurement; contract requirements were made more specific and new provisions added. The costs to the state for actuarial work, consulting and staff time were significant as well. The new vendor promised significant improvements in data systems and reporting to improve transparency. Millions of dollars were spent by each of the bidders, Value-Options, Optum Health, and Magellan.

## 6. Special Population Carve-Out

Some states, such as New Jersey and Florida's Child Welfare initiative, have elected to move into managed care for their children's system separately from their adult and disabled mental health systems. These "Special Population Carve-Outs" have some appeal because they allow states to focus exclusively on populations where the needs are most pronounced. New Jersey developed its ASO and county-based care management entity exclusively for behavioral health services to children and families. New funding resources made the adoption far easier than it would have otherwise been. Both Florida and New Jersey have sought to reduce the use of residential treatment as well as increase the coordination and use of community-based services.

Washington, D.C. has had an integrated health system for children eligible for SSI. This includes children with complex physical health needs, as well as mental illnesses. Given the complex needs of children in the child welfare system for mental and physical health care, WA could consider a special population carve-out approach that focuses on providing a comprehensive statewide, or perhaps regional, benefit for children in state custody. This approach can and should probably include funding from Medicaid, Children's administration and Institutional Review Board (IRB) since they are major funding sources for mental health and their needs are similar in many ways. For children in state custody, it

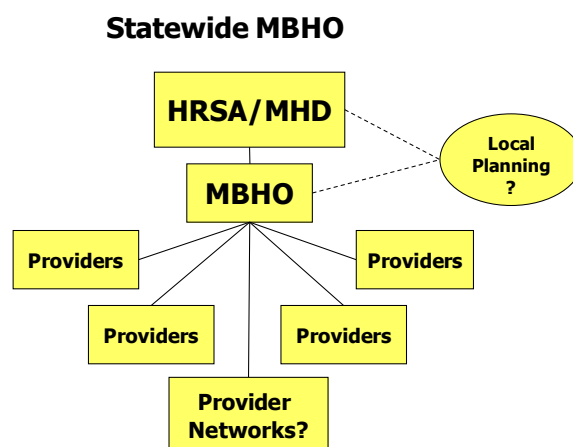


Figure 6: Statewide MBHO

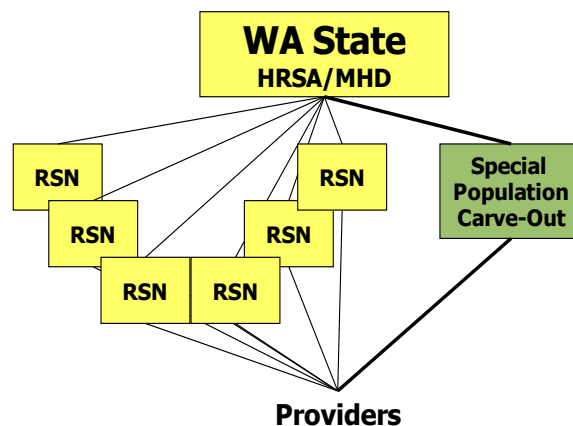


Figure 7: Special Population Carve-Out

may be desirable to include both health and behavioral health services. It is not immediately apparent whether any other population would be appropriate for this approach.

In addition to current goals, new goals of this approach would be to increase access to assessments and specialized services for children in state custody. As many are well aware, the needs of children and families are often lost in the development and oversight of the mental health system. The financing of these services should produce increased federal match for services since it appears that some of the services funded by the Children's Administration are not currently but could be matched by Medicaid. "Braided"<sup>34</sup> funding approaches of federal, state and local funds are increasingly seen as the optimal strategy by stakeholders because they promise greater interagency coordination and a more comprehensive benefit. They are quite complex to administer, however.

Disadvantages of the population carve-out include a reduced RSN enrollment and reducing the rates and the financial support of RSN administrative costs. Such a carve-out requires the development of a separate set of administrative systems, including customer supports, provider networks, claims and reporting systems. In many ways, it further breaks up the system, making billing and reporting more complex for providers who will have to respond to another payer. As with the overall system, the advantages of a statewide vs. regional approach should be considered for the population carve-out. Unless a behavioral health system is developed for all children, or special rules adopted, children in state custody will have to change their health plans as they leave custody or return home or to adoption.

## 7. Carve-In

With the recent research and attention on the healthcare needs of individuals with serious mental illnesses and the impact of mental illness on people with chronic illnesses, the integration of health and behavioral health services is increasingly important to policy makers.

One strategy to reduce the fragmentation of services that comes from behavioral health "carve-outs" is to purchase integrated services from health plans. The state could consider two approaches, both of which would profoundly change the existing system. The first involves some variant on the expansion of the Washington Medicaid Integration Partnership (WMIP), and the second would involve the statewide enrollment of SSI eligible adults in integrated health plans.

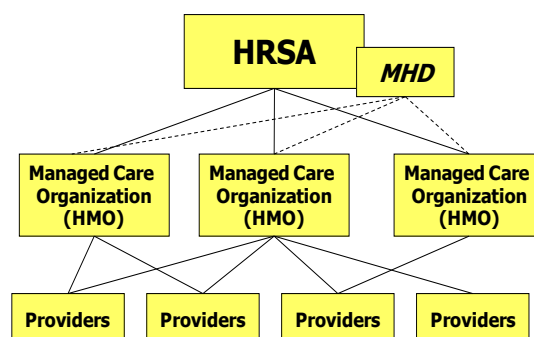


Figure 8: Carve-In

The WMIP in Snohomish is an excellent example of a complex integration effort that includes mental health services and long-term care. Like other carve-in models, WMIP provides financial incentives to improve health status and reduce health costs for people with mental illnesses, but the evidence of its success is inconclusive. The inclusion of long-term care services and the rules surrounding voluntary enrollment have added complexity for the program. As a pilot program and due to Medicaid rules, enrollment in the WMIP has been voluntary. This has led to disenrollment of individuals at key stages in their treatment particularly as their health needs and services have become more complex. As a result, any effort to bring the WMIP to scale should consider mandatory enrollment. A statewide expansion of this approach might also require a choice of health plans rather than a single plan. In addition, state officials should reconsider whether to include long-term care,

<sup>34</sup> Braided funding differs from "blended" funding approaches in that the eligibility and reporting requirements for different funding streams are maintained while integrated services are provided to meet the needs of youth across different funding streams.

since its inclusion leads to further complications. However, many consumers may feel that the alternative of mandatory enrollment without consumer choice of health plans is undesirable.

In Washington, current Medicaid managed care for physical health conditions has been limited to the Healthy Options program TANF recipients. Expanding enrollment to include SSI eligibles and carving in the mental health and substance abuse benefits would be a dramatic shift in the program. Nationally no vendors, with the possible exception of United Health Care, have solid experience in both healthcare and the provision of SMI/SED services. As a result, most plans would have to carve out their behavioral health services to a managed behavioral healthcare organization within the plan.

Given that the state is not enrolling SSI and the inconclusive evidence from WMIP, this option does not seem very desirable.

## 8. Chronic Disease Management Overlay

The primary drivers of health care costs are chronic diseases, and mental illnesses are among the most chronic. There has been significant promise from the Chronic Care Model and yet more evidence is needed in many areas<sup>35</sup>. Disease management (DM) strategies makes intuitive sense to most of us, yet the approaches used in DM with the Medicare pilots<sup>36</sup> have not proven to be cost-effective to date.

These issues notwithstanding, a chronic disease management strategy for Washington State could be overlaid on the existing or reduced RSN structure. It would involve the following activities: the identification of high cost or high risk individuals for enrollment, developing a data and tracking system, implementing telephonic and face to face intervention strategies (direct or under contract) for screening and assessment, providing referral to the RSNs and other services as appropriate, and tracking of outcomes and cost offsets. The scope of such an effort can be scaled to the available resources. State policymakers should consider developing an enhanced reimbursement strategy for the provision of a primary behavioral healthcare, when community mental health organizations or other approved providers assume responsibility for the coordination of care and implement appropriate data systems. Similar to a “medical home” model, these “recovery homes” could, at least conceptually, be paid with a monthly case rate for care coordination.

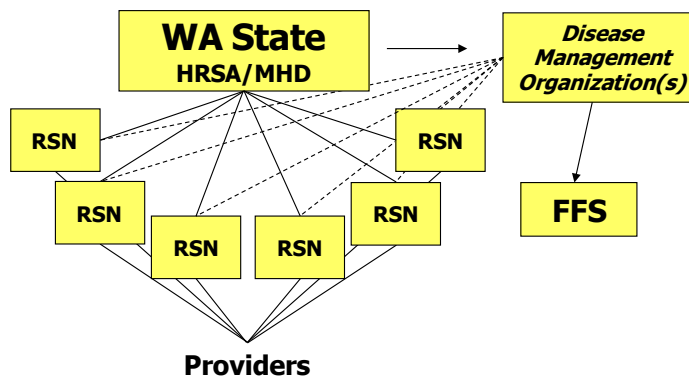


Figure 9: Chronic Disease Management

HRSA currently has the data systems and predictive modeling capability to identify almost 700 high-risk individuals. Data on claims for these individuals are available across multiple funding streams, including Medicaid, RSN, corrections, and other agencies. Approximately 50% of these individuals are enrolled in RSNs; the balance are fee-for-service recipients with mental health diagnoses or pharmacy benefits. The development of intervention strategies and recovery approaches for RSN enrollees and strategies for collaborative care with primary care clinicians could produce significant savings for HRSA. A reimbursement

<sup>35</sup> Katie Coleman, Brian T. Austin, Cindy Brach, and Edward H. Wagner. (2007) “Evidence on the Chronic Care Model in the New Millennium” *Health Affairs*, January/February 2009; 28(1): 75-85.

<sup>36</sup> David M. Bott, Mary C. Kapp, Lorraine B. Johnson, and Linda M. Magno. (2009) Disease Management for Chronically Ill Beneficiaries in Traditional Medicare. *Health Affairs*, January/February 2009; 28(1): 86-98.

strategy should be developed to provide incentives to community agencies or primary care for the physical health savings.

## 9. Return to Fee for Services

This option includes two variations. The first involves a return to fee for service and cancellation of the 1915B waiver. This is probably not a viable option due to the budgetary impact, if not in the first year – then in subsequent years. The second approach would be to amend the waiver, eliminating the RSN structures. The state would function as the managed care entity and the waiver would allow selective contracting and utilization management. The state would contract for the network, expanding the network beyond the current CMHA restrictions. Providers would be paid on a fee for services or perhaps on a risk basis such as a case rate. The state or a separate contractor would implement utilization management and quality assurance functions. There is only one example we are aware of currently where the state is in pre-paid health plans and this is the Children’s Mental Health Plan in Hawaii.

Returning to fee for service may be preferred by many providers and stakeholders. It would be perceived by many as providing access that is more open and it may reduce administrative costs. Clearly, the most significant disadvantage for pure fee-for-service is that it would carry an increased cost risk to the state for its Medicaid match requirements. This risk will grow over time unless the state has strong clinical standards and utilization management protocols. The state does not currently have a medical director or the skills needed for performing these managed care functions, so these functions would have to be brought into the Division. There is likely to be a reduced level of care coordination, though an aggressive implementation of chronic disease management strategies could provide a successful approach for cost savings and more effective collaborative care.

## CONCLUSIONS

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The need for changes in management and oversight of the system is clear to virtually everyone. Obviously, the recommended changes will differ based upon the perspectives and interests of each respondent. In this paper, the various options and approaches used by other states have been summarized and their advantages and disadvantages have been discussed. There are many approaches that other states have taken. Each approach has had different success in many states. The optimal approach in any state depends on the specific needs of the area; the competencies and experiences of the local organizations and personnel. The optimal approach also depends on the unique alignment of political and stakeholder forces in government and in local communities.

In Washington, there are clear advantages and also many current problems with the RSN structure. Having the Counties actively involved is important, but having an increased size and scale of regional entity would be a significant improvement in many ways. Using competition or perhaps just competitive forces can help to increase efficiency and motivate public change. Any change will require certain management improvements, new skills in staff and improved procedures. This may be where state administrators should begin.

New Mexico was able to achieve a potentially transformative change in financing and structure because of the leadership of the Governor and the current Secretary of Human Services and the careful and thoughtful efforts and resources taken to plan the system. Pennsylvania has also taken the time needed to implement an effective county-based system. Tennessee went through as many changes as they have because there was too little time taken to study and understand the behavioral health system, set sound rates and study the managed behavioral health market.

Clearly much is happening as a part of the Mental Health Transformation Project funded by the SAMHSA grant. Washington is showing tremendous leadership in developing many special planning and training initiatives. It is important that Washington move to make these efforts sustainable. To accomplish this will require that RSNs are formally engaged – perhaps required – to implement certain aspects of a recovery driven and evidence based system.

When the need for change is recognized in government programs, incremental change is sometimes harder to achieve than more radical steps. Having clear legislative intent is sometimes necessary to not only approve new legal structures and appropriate funds, but also to clearly grant authority to agencies to execute the tasks. This seems to have been part of the problem in Washington to date.

People in public and private organizations resist change most often because they don't understand it. They may not understand the need, the options available, changes being proposed or the implications of the changes on their jobs or the people they serve. Taking the time and effort to develop detailed plans and listen to concerns can convert stakeholders into advocates of change. Focusing on data and making small, meaningful changes can make a profound difference in a system's readiness for change. By using data and systematically addressing the complex issues needed to reduce state hospital census, increase community access rates, improve primary care collaboration, and reduce readmission rates or disparities, purchasers can address the root causes of these issues without increasing resistance. Using QI approaches, collaborative planning, providing proper incentives, effective network management and adopting a recovery and resiliency approach can truly transform the mental health delivery system.

The needs for many of the improvements have been described in various reports prepared under the auspices of the Mental Health Division, the Transformation Working Group, the EQRO report and in studies by the various Institutes at the University of Washington over the last several years. The time for the implementation of many of these changes has come, whether through redesign or the implementation of management improvements. Success will require clear guidance, delegated authority, a commitment to change by all parties and effective project management to complete them. In collaboration with its sister Divisions and Agencies, and with the benefit of the work of the Transformation Working Group, the Mental Health Division can translate its vision of recovery and resiliency and the recommendations of many stakeholders into concrete actions to improve care.

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